Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WALTER A DEL GALLO PA MD
14317 NORTHWEST BLVD SUITE A
CORPUS CHRISTI TEXAS 78410

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M-12-0050-01

MFDR Date Received
September 2, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per compensation 133.240. The first 12 session should not need prior authorization."

Amount in Dispute: $1,160.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Rule 134,600 at (p)(5)(C)(i) states in part that preauthorization is required 'except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following...the date of injury... The date of injury is 2/27/11. Two weeks is the same as 14 days. Fourteen days from 2/27/11 is 3/31/11. The requestor's disputed dates above are outside the two week period allowed by Rule 134.600."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 31, 2011 through April 26, 2011	97110, 97001	$1,160.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline reimbursement for professional services.
3. 28 Texas Administrative Code §134.600 sets out the preauthorization, concurrent review and voluntary certification of healthcare guidelines.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 29, 2011
   - 197 – Precertification/authorization/notification absent.
   - 930 – Pre-authorization required, reimbursement denied.

Issues

1. Did the physical therapy services rendered on March 31, 2011 through April 26, 2011 require preauthorization?
2. Did the insurance carrier reimburse the requestor for CPT code 97001 rendered on March 31, 2011?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600 states in pertinent part "(p) Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following (i) the date of injury; or (ii) a surgical intervention previously preauthorized by the insurance carrier..."
   - The requestor disputes non-payment of CPT codes 97110 and 97001 rendered on March 31, 2011 through April 26, 2011.
   - The requestor states in pertinent part, "The First 12 session should not need prior authorization.."
   - Review of the submitted documentation does not document that the treatment rendered was the first six visits of physical therapy following the evaluation when such treatment is rendered within the first two weeks immediately following the date of injury or a surgical intervention previously preauthorized by the insurance carrier.
   - Preauthorization was required for the disputed physical therapy services and was not obtained by the requestor. Therefore, MFDR cannot recommend reimbursement for CPT codes 97110 and 97001 rendered on March 31, 2011 through April 26, 2011.
   - The requestor billed CPT 97001 on March 31, 2011. CPT code 97001 is defined as "Physical therapy evaluation" and does not require preauthorization. Therefore the disputed charge will be reviewed according to the applicable fee guidelines.
2. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83... (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."
   - Review of the EOB dated June 29, 2011 documents that CPT code 97001 was reimbursed by the insurance carrier in the amount of $110.00 under invoice number 000009499517. Therefore additional reimbursement cannot be recommended for CPT code 97001.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		May 23, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.